

		FOR OHF USE					

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2003  
STATE OF ILLINOIS  
DEPARTMENT OF PUBLIC AID  
FINANCIAL AND STATISTICAL REPORT FOR  
LONG-TERM CARE FACILITIES  
(FISCAL YEAR 2003)

IMPORTANT NOTICE  
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p>I. IDPH Facility ID Number: 0040188</p> <p>Facility Name: Boyd Avenue Home</p> <p>Address: 1105 S. Boyd Amboy 61310 Number City Zip Code</p> <p>County:</p> <p>Telephone Number: (815) 288-6691 Fax # (815) 288-1636</p> <p>IDPA ID Number: 23-7417424005</p> <p>Date of Initial License for Current Owners: 09/17/93</p> <p>Type of Ownership:</p> <table><tr><td><input checked="" type="checkbox"/></td><td>VOLUNTARY,NON-PROFIT</td><td><input type="checkbox"/></td><td>PROPRIETARY</td><td><input type="checkbox"/></td><td>GOVERNMENTAL</td></tr><tr><td><input checked="" type="checkbox"/></td><td>Charitable Corp.</td><td><input type="checkbox"/></td><td>Individual</td><td><input type="checkbox"/></td><td>State</td></tr><tr><td><input type="checkbox"/></td><td>Trust</td><td><input type="checkbox"/></td><td>Partnership</td><td><input type="checkbox"/></td><td>County</td></tr><tr><td>IRS Exemption Code</td><td></td><td><input type="checkbox"/></td><td>Corporation</td><td><input type="checkbox"/></td><td>Other</td></tr><tr><td></td><td></td><td><input type="checkbox"/></td><td>"Sub-S" Corp.</td><td></td><td></td></tr><tr><td></td><td></td><td><input type="checkbox"/></td><td>Limited Liability Co.</td><td></td><td></td></tr><tr><td></td><td></td><td><input type="checkbox"/></td><td>Trust</td><td></td><td></td></tr><tr><td></td><td></td><td><input type="checkbox"/></td><td>Other</td><td></td><td></td></tr></table> <p>In the event there are further questions about this report, please contact: Name: Edward S. Roller Telephone Number: (815) 288-6691</p>	<input checked="" type="checkbox"/>	VOLUNTARY,NON-PROFIT	<input type="checkbox"/>	PROPRIETARY	<input type="checkbox"/>	GOVERNMENTAL	<input checked="" type="checkbox"/>	Charitable Corp.	<input type="checkbox"/>	Individual	<input type="checkbox"/>	State	<input type="checkbox"/>	Trust	<input type="checkbox"/>	Partnership	<input type="checkbox"/>	County	IRS Exemption Code		<input type="checkbox"/>	Corporation	<input type="checkbox"/>	Other			<input type="checkbox"/>	"Sub-S" Corp.					<input type="checkbox"/>	Limited Liability Co.					<input type="checkbox"/>	Trust					<input type="checkbox"/>	Other			<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/02 to 06/30/03 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table><tr><td rowspan="3">Officer or Administrator of Provider</td><td>(Signed)</td><td></td><td>(Date)</td><td></td></tr><tr><td>(Type or Print Name)</td><td colspan="3">Edward S. Roller</td></tr><tr><td>(Title)</td><td colspan="3">Director of Finance</td></tr><tr><td rowspan="5">Paid Preparer</td><td>(Signed)</td><td></td><td>(Date)</td><td></td></tr><tr><td>(Print Name and Title)</td><td></td><td></td><td></td></tr><tr><td>(Firm Name &amp; Address)</td><td></td><td></td><td></td></tr><tr><td>(Telephone)</td><td>( )</td><td>Fax # ( )</td><td></td></tr><tr><td colspan="4">MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</td></tr></table>	Officer or Administrator of Provider	(Signed)		(Date)		(Type or Print Name)	Edward S. Roller			(Title)	Director of Finance			Paid Preparer	(Signed)		(Date)		(Print Name and Title)				(Firm Name & Address)				(Telephone)	( )	Fax # ( )		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630			
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Facility Name & ID Number Boyd Avenue Home

# 0040188 Report Period Beginning: 07/01/02 Ending: 06/30/03

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds \_\_\_\_\_

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	5,856	6
7	16	TOTALS	16	5,856	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,783			5,783	13
14	TOTALS	5,783			5,783	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 98.75%

D. How many bed-hold days during this year were paid by Public Aid? 58 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

F. Does the facility maintain a daily midnight census? yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?  
YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?  
YES ☐ NO ☒

I. On what date did you start providing long term care at this location?  
Date started 09/17/93

J. Was the facility purchased or leased after January 1, 1978?  
YES ☒ Date 02/17/94 NO ☐

K. Was the facility certified for Medicare during the reporting year?  
YES ☐ NO ☒ If YES, enter number of beds certified \_\_\_\_\_ and days of care provided \_\_\_\_\_

Medicare Intermediary \_\_\_\_\_

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH\* ☐ CASH\* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 06/30/03 Fiscal Year: 06/30/03

\* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number **Boyd Avenue Home** # **0040188** Report Period Beginning: **07/01/02** Ending: **06/30/03**  
**V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>A. General Services</b>											
1	Dietary	50,571		781	51,352		51,352		51,352			1
2	Food Purchase		38,635		38,635		38,635		38,635			2
3	Housekeeping	46,383	4,956		51,339		51,339		51,339			3
4	Laundry	23,193			23,193		23,193		23,193			4
5	Heat and Other Utilities			14,769	14,769		14,769		14,769			5
6	Maintenance	23,637	10,072	3,157	36,866		36,866		36,866			6
7	Other (specify):*			552	552		552		552			7
8	<b>TOTAL General Services</b>	143,784	53,663	19,259	216,706		216,706		216,706			8
	<b>B. Health Care and Programs</b>											
9	Medical Director											9
10	Nursing and Medical Records	235,962	4,885	3,046	243,893		243,893		243,893			10
10a	Therapy			72	72		72		72			10a
11	Activities	16,521	4,403		20,924		20,924		20,924			11
12	Social Services	2,575		107	2,682		2,682		2,682			12
13	Nurse Aide Training	7,200			7,200		7,200		7,200			13
14	Program Transportation			13,084	13,084		13,084		13,084			14
15	Other (specify):* <b>Client Advocate</b>	2,691	709		3,400		3,400		3,400			15
16	<b>TOTAL Health Care and Programs</b>	264,949	9,997	16,309	291,255		291,255		291,255			16
	<b>C. General Administration</b>											
17	Administrative	65,960		77,373	143,333		143,333		143,333			17
18	Directors Fees											18
19	Professional Services											19
20	Dues, Fees, Subscriptions & Promotions			2,637	2,637		2,637		2,637			20
21	Clerical & General Office Expenses		3,706	4,828	8,534		8,534		8,534			21
22	Employee Benefits & Payroll Taxes			171,107	171,107		171,107		171,107			22
23	Inservice Training & Education			2,408	2,408		2,408		2,408			23
24	Travel and Seminar			4,505	4,505		4,505		4,505			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			5,248	5,248		5,248		5,248			26
27	Other (specify):*											27
28	<b>TOTAL General Administration</b>	65,960	3,706	268,106	337,772		337,772		337,772			28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	474,693	67,366	303,674	845,733		845,733		845,733			29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			28,829	28,829		28,829		28,829			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			4,624	4,624		4,624		4,624			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			4,373	4,373		4,373		4,373			34
35	Rent-Equipment & Vehicles			264	264		264		264			35
36	Other (specify):*											36
37	TOTAL Ownership			38,090	38,090		38,090		38,090			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			59,968	59,968		59,968		59,968			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			59,968	59,968		59,968		59,968			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	474,693	67,366	401,732	943,791		943,791		943,791			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.  
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$		\$	30

OHF USE ONLY							
48		49		50		51	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B) )	\$		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.  
(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

## Summary A

06/30/03

[illegible]

## Summary B

**06/30/03**

## SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

[illegible]



VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Kreider Services, Inc.	100	Pine Acres Group Home	Dixon			
Kreider Services, Inc.	100	Blackhawk Group Home	Dixon			
Kreider Services, Inc.	100	Ashton Terrace Group Home	Ashton			
Kreider Services, Inc.	100	New Main Group Home	Dixon			
Kreider Services, Inc.	100	Franklin Grove, Ottawa, First S. Group Home	Franklin Grove, Dixon, Ashton			
Kreider Services, Inc.	100	Amboy Terrace Group Home	Amboy			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☒ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1  Name	2  Title	3  Function	4  Ownership Interest	5  Compensation Received From Other Nursing Homes*	6  Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7  Compensation Included in Costs for this Reporting Period**		8  Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number      Boyd Avenue Home      #    0040188    Report Period Beginning:      07/01/02      Ending:    06/30/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.)      YES ☒      NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization      Kreider Services, Inc.  
Street Address      500 Anchor Rd.  
City / State / Zip Code      Dixon, Illinois 61021  
Phone Number      ( 815) 288-6691  
Fax Number      ( 815) 288-1636

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	<a href="#">Ln 17, Col 3</a>	<a href="#">Admin Salaries</a>	<a href="#"># of clients</a>		25	\$ 817,543	\$ 817,543		\$ 51,182	1
2	<a href="#">Ln 17, Col 3</a>	<a href="#">Fringe Benefits</a>	<a href="#"># of clients</a>		25	229,850			14,378	2
3	<a href="#">Ln 17, Col 3</a>	<a href="#">Utilities</a>	<a href="#">Sq. Feet/ # of clients</a>		25	4,807			301	3
4	<a href="#">Ln 17, Col 3</a>	<a href="#">Maint./Rep. Bldg., grounds,equip</a>	<a href="#">Sq. Feet/ # of clients</a>		25	0				4
5	<a href="#">Ln 17, Col 3</a>	<a href="#">Maint./Rep-Contractual</a>	<a href="#">Sq. Feet/ # of clients</a>		25	6,310			395	5
6	<a href="#">Ln 17, Col 3</a>	<a href="#">Maint./Rep-Vehicle</a>	<a href="#"># of clients</a>		25	1,208			75	6
7	<a href="#">Ln 17, Col 3</a>	<a href="#">Misc.</a>	<a href="#"># of clients</a>		25	543			34	7
8	<a href="#">Ln 17, Col 3</a>	<a href="#">Legal Audit, Etc.</a>	<a href="#"># of clients</a>		25	50,126			3,143	8
9	<a href="#">Ln 17, Col 3</a>	<a href="#">Dues &amp; Membership</a>	<a href="#"># of clients/ICFDD &amp; DT</a>		25	27,157			2,158	9
10	<a href="#">Ln 17, Col 3</a>	<a href="#">Office Supplies, Postage</a>	<a href="#"># of clients</a>		25	26,825			1,678	10
11	<a href="#">Ln 17, Col 3</a>	<a href="#">Telephone</a>	<a href="#"># of clients</a>		25	5,724			358	11
12	<a href="#">Ln 17, Col 3</a>	<a href="#">Training</a>	<a href="#"># of clients</a>		25	6,930			435	12
13	<a href="#">Ln 17, Col 3</a>	<a href="#">Travel Costs</a>	<a href="#"># of clients</a>		25	4,887			306	13
14	<a href="#">Ln 17, Col 3</a>	<a href="#">Insurance-Auto/Prop</a>	<a href="#"># of clients</a>		25	5,965			373	14
15	<a href="#">Ln 17, Col 3</a>	<a href="#">Depreciation</a>	<a href="#"># of clients</a>		25	11,506			720	15
16	<a href="#">Ln 17, Col 3</a>	<a href="#">Building Rent</a>	<a href="#"># of clients</a>		25	22,277			1,395	16
17	<a href="#">Ln 17, Col 3</a>	<a href="#">Consulting Exp.-Other Prof.</a>	<a href="#"># of clients</a>		25	0			442	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,221,658	\$ 817,543		\$ 77,373	25

06/30/03

**A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)**

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1	Kreider Services Foundation		X	Mortgage	\$6,323.00	02/01/94	\$ 533,000	\$ 27,070	09/01/03	0.0700	\$ 4,625	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related				\$6,323.00		\$ 533,000	\$ 27,070			\$ 4,625	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 533,000	\$ 27,070			\$ 4,625	15	

**Line #**      **n/a**

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.)

**\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)**

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. **This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates    RE: 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

Boyd Avenue Home

COUNTY

FACILITY IDPH LICENSE NUMBER

0040188

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( )

FAX #: ( )

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A)	(B)	(C)	(D)
				<u>Tax</u>
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to</u>
				<u>Nursing Home</u>
1.			\$	\$
2.			\$	\$
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$	\$

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?    YES    NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home.  
(Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 2184,2184,1784

B. General Construction Type: Exterior BRICKFrame WOODNumber of Stories 1

C. Does the Operating Entity?

☒ (a) Own the Facility

☐ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☐ (c) Rent equipment from Completely Unrelated Organization.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES

☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Building		1994	\$ 48,286	1
2	Land Improvement		1995	2,079	2
3	TOTALS			\$ 50,365	3

Facility Name & ID Number Boyd Avenue Home

# 0040188

Report Period Beginning:

07/01/02

Ending:

06/30/03

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	FOR OHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	6		1994	1993	\$ 176,334	\$ 7,054	25	\$ 7,054	\$	66,596	4
5	6		1994	1993	176,334	7,053	25	7,053		66,419	5
6	4		1994	1993	146,555	5,862	25	5,862		55,203	6
7											7
8											8
	Improvement Type**										
9	Blacktop Alley-Wasson			1995	875	88	10	88		664	9
10	Carpet & Vinyl Flooring-Boyd			2000	3,129	313	10	313		939	10
11	Living Area, Office, Hall carpet-Division			2000	2,637	527	5	527		1,450	11
12	Carpet-Wasson			2000	2,639	528	5	528		1,495	12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total



XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 508,503	\$ 21,425		\$ 21,425	\$	\$ 192,766	70

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)								
	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 33,651	\$ 2,502	\$ 2,502	\$		\$ 18,847	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 33,651	\$ 2,502	\$ 2,502	\$		\$ 18,847	75

D. Vehicle Depreciation (See instructions.)*									
	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9
76	Residential Transport	94 Dodge Caravan (35)	1994	\$ 14,500	\$ 0	\$ 0	\$	4	\$ 14,500
77	Residential Transport	96 Dodge Van 15-pass (33)	1995	21,039	0	0		4	21,039
78									78
79									79
80	TOTALS			\$ 35,539	\$	\$	\$		\$ 35,539

E. Summary of Care-Related Assets					1	2
		Reference			Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)			\$ 628,058	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$ 23,927	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$ 23,927	
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$ 247,152	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)				
	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4
86	Corporate Equipment	\$	\$ 2,745	\$
87	Corporate Vehicle		247	
88	Corporate Leasehold Improvement		1,910	
89				
90				
91	TOTALS	\$	\$ 4,902	\$

G. Construction-in-Progress		
	Description	Cost
92		\$
93		28,829
94		
95		\$ 28,829

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?  
If NO, see instructions.
- ☐ YES
- ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

\*\*

8. List separately any amortization of lease expense included on page 4, line 34.  
This amount was calculated by dividing the total amount to be amortized  
by the length of the lease N/A.
- 
- 

9. Option to Buy:
- ☐ YES
- ☐ NO
- Terms:
- \*

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?
- ☐ YES
- ☐ NO
16. Rental Amount for movable equipment: \$
- Description:

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	\$
13.	/2005	\$
14.	/2006	\$

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?

☒ YES

☐ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER AIDE

☒

☐

☐

50

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER AIDE

☒

☐

80

B. EXPENSES

ALLOCATION OF COSTS (d)

		1		2		3	4
		Facility					
		Drop-outs	Completed	Contract		Total	
1	Community College Tuition	\$	\$	\$		\$	
2	Books and Supplies						
3	Classroom Wages (a)		2,769			2,769	
4	Clinical Wages (b)		4,430			4,430	
5	In-House Trainer Wages (c)						
6	Transportation						
7	Contractual Payments						
8	Nurse Aide Competency Tests						
9	TOTALS	\$	\$ 7,199	\$		\$ 7,199	
10	SUM OF line 9, col. 1 and 2 (e)	\$	7,199				

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	6
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	6

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 2,400	\$ 5,212,278	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	174,327	1,649,815	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance		(152,107)	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):		203,026	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 176,727	\$ 6,913,012	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		326,183	13
14	Buildings, at Historical Cost		4,128,450	14
15	Leasehold Improvements, at Historical Cost		630,755	15
16	Equipment, at Historical Cost		2,210,038	16
17	Accumulated Depreciation (book methods)		(3,468,912)	17
18	Deferred Charges		7,009	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Deposit with NIA</u>		780	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$	\$ 3,834,303	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 176,727	\$ 10,747,315	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$	\$ 109,130	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	25,495	725,263	30
31	Accrued Taxes Payable (excluding real estate taxes)		7,698	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable		15,680	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>See Attached List</u>	3,150	111,521	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 28,645	\$ 969,292	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable		1,039,324	40
41	Bonds Payable		1,595	41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>PLUG</u>	(738,677)		43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ (738,677)	\$ 1,040,919	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ (710,032)	\$ 2,010,211	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 886,759	\$ 8,737,104	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 176,727	\$ 10,747,315	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 789,790	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 789,790	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	96,969	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 96,969	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 886,759	24 *

\* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.  
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 1,012,349	1
2	Discounts and Allowances for all Levels	( )	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,012,349	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	12,138	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 12,138	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,915	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,915	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc. Income	12,678	28
28a	QMRP Training Income	680	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 13,358	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,040,760	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	216,706	31
32	Health Care	291,255	32
33	General Administration	337,772	33
	B. Capital Expense		
34	Ownership	38,090	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	59,968	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 943,791	40
41	Income before Income Taxes (line 30 minus line 40)**	96,969	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 96,969	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return?                      If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.



XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)  
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing			\$	\$	1
2	Assistant Director of Nursing					2
3	Registered Nurses	187	224	4,561	20.36	3
4	Licensed Practical Nurses	864	1,016	14,858	14.62	4
5	Nurse Aides & Orderlies					5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	1,427	1,565	16,521	10.56	10
11	Social Service Workers	189	221	2,575	11.65	11
12	Dietician					12
13	Food Service Supervisor	115	139	2,043	14.70	13
14	Head Cook	173	209	2,145	10.26	14
15	Cook Helpers/Assistants	4,180	4,582	46,383	10.12	15
16	Dishwashers					16
17	Maintenance Workers	1,781	2,079	23,637	11.37	17
18	Housekeepers	4,180	4,582	46,383	10.12	18
19	Laundry	2,091	2,290	23,193	10.13	19
20	Administrator					20
21	Assistant Administrator	4,687	5,135	65,960	12.85	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	2,000	2,239	29,691	13.26	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	17,528	19,121	194,052	10.15	30
31	Medical Records					31
32	Other Health Care: client advoc/beh sp	131	146	2,691	18.43	32
33	Other(specify) other contract staff					33
34	TOTAL (lines 1 - 33)	39,533	43,548	\$ 474,693 *	\$ 10.90	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$ 781	Ln.1, Col. 3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		972	Ln.10, Col. 3	39
40	Physical Therapy Consultant		72	Ln.10a,Col.3	40
41	Occupational Therapy Consultant		0	Ln.10a,Col.3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant		0	Ln.10a,Col.3	43
44	Activity Consultant		0	Ln.11, Col.3	44
45	Social Service Consultant		0	Ln.12, Col.3	45
46	Other(specify) Behavior Specialist		440	Ln.10, Col.3	46
47	Physician/Psychologist/Dentist		1,634	Ln.10, Col.3	47
48	Other-Professional			Ln.17, Col.3	48
49	TOTAL (lines 35 - 48)		\$ 3,899		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

STATE OF ILLINOIS

Facility Name & ID Number

Boyd Avenue Home

# 0040188Report Period Beginning: 07/01/02Ending: 06/30/03Page 21

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name

Function

Ownership

Amount

R. Heiderscheit/S. Lenzi

Manager

\$ 13,172

C.Johnson/D. Inman/C.Joyce/

Supervisor

52,788

P. Willis

TOTAL (agree to Schedule V, line 17, col. 1)

(List each licensed administrator separately.)

\$ 65,960

B. Administrative - Other

Description

Amount

Allocation of Management & General

\$ 77,373

TOTAL (agree to Schedule V, line 17, col. 3)

(Attach a copy of any management service agreement)

\$ 77,373

C. Professional Services

Vendor/Payee

Type

Amount

\$

TOTAL (agree to Schedule V, line 19, column 3)

(If total legal fees exceed \$2500 attach copy of invoices.)

\$

D. Employee Benefits and Payroll Taxes

Description

Amount

Workers' Compensation Insurance

\$ 42,082

Unemployment Compensation Insurance

2,538

FICA Taxes

34,747

Employee Health Insurance

80,255

Employee Meals

Illinois Municipal Retirement Fund (IMRF)\*

403B Pension Plan

6,783

Tuition Reimbursement

766

E.A.P.

Christmas Gift/Party

1,811

Physical Exam

400

Accrued Vacation Pay

1,725

TOTAL (agree to Schedule V,

line 22, col.8)

\$ 171,107

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description

Line #

Amount

\$

TOTAL

\$

F. Dues, Fees, Subscriptions and Promotions

Description

Amount

IDPH License Fee

\$ 800

Advertising: Employee Recruitment

597

Health Care Worker Background Check

16

(Indicate # of checks performed 1 )

Subscription

555

Dues

205

Misc. Fees

464

Vehicle License

Bond Fee

Allocated Fees(survey fee)

Less: Public Relations Expense

( )

Non-allowable advertising

( )

Yellow page advertising

( )

TOTAL (agree to Sch. V,

line 20, col. 8)

\$ 2,637

G. Schedule of Travel and Seminar\*\*

Description

Amount

Out-of-State Travel

\$ 0

In-State Travel

4,505

Seminar Expense

0

Entertainment Expense

( )

(agree to Sch. V,

line 24, col. 8)

TOTAL

\$ 4,505

\* Attach copy of IMRF notifications

\*\*See instructions.



## XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report?  
If YES, give association name and amount. NO
- (3) Did the nursing home make political contributions or payments to a political  
action organization? NO If YES, have these costs  
been properly adjusted out of the cost report? \_\_\_\_\_
- (4) Does the bed capacity of the building differ from the number of beds licensed at the  
end of the fiscal year? NO If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? YES  
What was the average life used for new equipment added during this period? 5 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense  
and the location of this expense on Sch. V. \$ N/A Line \_\_\_\_\_
- (7) Have all costs reported on this form been determined using accounting procedures  
consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for  
Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility,  
IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department  
of Public Aid during this cost report period. \$ 59,968  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V  
for an individual employee? \_\_\_\_\_ If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? N/A For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? N/A Indicate the amount. \$ 0
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? NO  
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 0
- c. What percent of all travel expense relates to transportation of nurses and patients? 100%
- d. Have vehicle usage logs been maintained? NO
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? YES  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? YES  
Firm Name: CLIFTON GUNDERSON LLP The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? NO If no, please explain. It is not yet completed
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? N/A
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees